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ABSTRACT

Improved health care and family planning services, reduction in sociogeographic isolation, and increased economic development were found to be responsible for declining fertility rates in a rural Eastern Kentucky county during 1960-1980. Contemporary fertility patterns in an area historically exhibiting one of Appalachia's highest fertility rates were found to be similar to patterns throughout the United States. Interviews with 407 married women under 45 years of age measured demographic factors, perception of availability/accessibility of family planning services, approval of birth control, family size preferences, knowledge and use of contraceptives, and effectiveness of fertility regulation. Results were compared by age group. Educational levels were found to decrease as age increased, employment increased with age, and family income was highest in the middle age group. Similarities were found among women in the three age groups in level of birth control approval and use and motivation toward family limitation. Differences were found in initial timing and method of contraceptive practice and effectiveness of fertility regulation. Younger women knew about and started using birth control at an earlier age, were more effective in fertility regulation, and more successful in achieving family size goals. Tables provide data on population and perceived availability of family planning services. (LFL)

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The Demographic Transition In An Appalachian Community

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THE DEMOGRAPHIC TRANSITION IN AN APPALACHIAN COMMUNITY

Relatively "low fertility" levels have become a widespread phenomenon of human reproduction in contemporary American society. The use of modern birth control methods among married couples to achieve usually small family size preferences has been a major factor in this general pattern of "low fertility." However, differentials in the adoption of "small family size" ideals and/or goals are also quite evident for certain groups, at least in terms of observed differential fertility rates and trends (Population Bulletin, June 1982). This latter situation has often been the case for many of the more rural and historically "high fertility" areas of Central Appalachia (DeJong, 1968; Brown, 1972).

This paper reports preliminary findings from recent research in such a rural Appalachian community. Following a brief description of the study community and research approach, the discussion will focus on selected findings from this work which demonstrate: 1) the rather significant decline in the fertility trends in this "traditionally" high fertility community over the past fifteen years or so, and 2) the very striking similarity of the contemporary fertility patterns in the local area to those found among most other American families today.

The study community is an extremely mountainous, rural county located in the Eastern Kentucky region of Central Appalachia. Major roads came late to this county, and even today its variegated hills and narrow valleys coupled with poor local roads produce a relatively high level of geographic isolation for some sections of the county. These physical conditions have had a significant impact on local economic activities and development; agriculture has been almost exclusively subsistence; the commercial wood industry,

like that throughout much of the region, has been constricted by early clear-cutting practices and other resource management problems; and coal mining in the county did not develop as a fully established commercial enterprise until the "boom years" of the 1940's. In fact, even up into and during the 1950-60 decade, the county was identified in terms of its physical, economic, and cultural characteristics as being in the area of "maximum" isolation and "lowest" development throughout the entire region of Eastern Kentucky. (Bowman and Haynes, 1963). Indeed, since the "great depression" of the 1930's and the deep post World War II economic decline and "poverty years" of the early 1960's in this region, local government employment and federal-state transfer payments have become two major sources of personal income for many individuals and families in the county (Sutton and Russell, 1964; Ramsey and Warner, 1974). The county has been and remains to some degree, therefore, a relatively "poorer" rural community from an economic standpoint in comparison to various other rural areas of the state and nation.

Our recently completed field research in this community involved a three-year multimethod study of the county. The primary objectives of the study were: 1) first to describe the current fertility regulation perceptions, attitudes, and practices in the community, and 2) second to discern the most significant factors associated with the observed fertility regulation patterns. The major phases of the field work and related data collection activities for the study were carried out in the community over a two-year period from roughly Sept. 1980 to Sept. 1982. During this period, an anthropologist member of the research team served as the project field coordinator and lived in the county gathering available documents, ethnographic and other data on the historical development and contemporary milieu of the community, and the current community services and attitudes relating to fertility regulation. In addition, the team conducted a county-wide survey consisting

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of two waves of interviews with married women in the child bearing ages who are members of families with intact conjugal units. The focus of the interview was on major factors affecting their birth control and fertility management practices. This multidisciplinary research strategy is designed to bring the community study and social survey methods together in a unified community-based study of the communal, familial, and individual context of human reproduction and fertility behavior in the local population (Hochstrasser, Arthur, and Lewis, 1973).

FERTILITY TRENDS: REGIONAL AND COUNTY

Population and demographic data on the county from the U.S. Census and other available sources indicate that in conjunction with its relatively pronounced geographic and economic isolation in the past, the county has historically exhibited a fertility level much higher than that of Southern Appalachia in general; a region with birth rates significantly higher than the rest of the nation well up to the 1950's (DeJong, 1968). As indicated in Table 1, during the 1950-1960 decade the community experienced a relatively high level of outmigration, along with other rural counties and areas in the region (DeJong, 1961). However, while this also was the decade of "the great decline in Southern Appalachian fertility," the study community remained a relatively "high fertility" county through this decade and into the early 1960's. In fact, as DeJong (1968:50-51) points out: "The largest constellations of high fertility counties" in Southern Appalachia during this decade were "in eastern Kentucky, West Virginia, and on the western edge of the plateau area of Tennessee. And at the end of the decade in 1960, "eastern Kentucky counties stand out as the highest fertility areas", especially the county under study here "where the general fertility rate of 235 was extraordinarily high."

Yet, since the mid-late 1960's, the county has undergone both a further and somewhat accelerated reduction in its earlier "sociogeographic isolation" and a rather dramatic "demographic transition" from an exceptionally "high" to a moderately "low" fertility level; with crude birth rates declining from 43.1 in 1960 to 17.7 in 1980; and general fertility rates declining from 235.3 in 1960 to 72.9 in 1980. It should be noted here that the general historical pattern of reduction in the county's earlier and rather pronounced isolation appears to have actually started, at least to any discernible degree, somewhere around the late New Deal-WWII period and proceeded somewhat steadily up through the following post-WWII eras.

As can be seen in Table 2, the greatest rate of fertility decline in the county over the past twenty years occurred during the 1960-70 decade; but it wasn't until the following 1970-80 decade that this decline continued at a high enough rate to bring the community to a fertility level roughly on a par with that of the state and nation. There is general agreement that at least part of the "great fertility decline" of the 1950-60 decade in Southern Appalachia was due to the heavy out migration of large numbers of young and middle age people from the region during this period (DeJong,1968). Likewise, it has been suggested (Brown 1972:142-43) that the "prime factor" responsible for the decline in birth and fertility rates "in the counties of eastern Kentucky" during the following 1960-70 decade also was "the migration of such large numbers of young people in the child-producing ages." This does not appear to hold, however, for the particular county among these eastern Kentucky counties under study here. As Table 3 shows, the number of young and middle aged women in the child-bearing ages (15-44 yrs.) actually increased in the county as the birth and fertility rates decreased during this period, as well as during the following 1970-80 decade.

In addressing this general problem of historical explanation, it is noteworthy that the transition from exceptionally "high" to moderately "low" birth and fertility rates in the county occurred during a period when the community was also experiencing a continued and somewhat more rapid economic development and sociocultural integration into the larger state/national society, and when more intensive "outside" and "local" efforts at improved health care and family planning services appeared under the general auspices of both public and private programs. With the event of World War II, this accelerated process of physical, economic, and social transition has been underway throughout much of rural Central Appalachia. Hence, as Photiadis (1978:3-4) points out: "In recent years a number of drastic cultural changes, particularly technological ones ..., have affected the isolation of the region and, in turn, the relationship between the region and the larger American society." In short, since World War II, television, mobile homes, consolidated schools, new industry, large scale surface ("strip") mining, decent roads and modern health facilities (among other things) have forever altered both the mountains and the people of eastern Kentucky.

Overall, then one of the more distinctive features of this particular county from a general or modern developmental standpoint is the fact that it seems to have lagged about a decade or so behind compared to various other rural counties and areas in Central Appalachia. Consequently, some of the more significant reductions in its sociogeographic isolation, together with some of the major improvements in its socioeconomic status and significant decreases in its fertility, all came relatively late and appear to have occurred largely during the period from around the mid to late 1960's through the 1970-80 decade.

This general pattern of increased development accompanied by decreased fertility in the study community over the past twenty years appears to fit

very nicely with the "developmental model" of population growth in modern society; which stresses "the role of socioeconomic development in producing fertility decline." (Teachman, et al., 1983). In its general formulation, this model builds on the widely recognized "reciprocal relationhip" between socioeconomic development and population growth. High population growth rates are generally associated with low levels of socioeconomic development, whereas high levels of socioeconomic development are almost universally associated with low population growth rates. This position is usually argued in terms of "reciprocal causality"; whereby "sustained development, with concomitant changes in the status of women and in the economic value of children, leads to lower fertility and therefore lower rates of population growth (Davis 1963; Ryder 1976)." (Teachman, et al., 1983).

It is important to remember, however, that this widely recognized "reciprocal relationship" between population growth and socioeconomic development is essentially a historical phenomenon, at least as it applies in the present study. It involves only an observed association between certain socioeconomic and demographic trends which happen to have occurred and/or coincided during the same time period. In other words, in many cases the assumption of "reciprocal causality", on which the argument for the "developmental model" is usually based, represents nothing more than a set of historical phenomena and associations. The so-called relationship, therefore, is primarily a statistical or correlational relation or, that is, association. Hence, it does not represent any sort of actually established cause-effect relationship in which increased socioeconomic development necessarily produces decreased fertility; or, more precisely, increased family limitation or birth control which in turn leads to decreased fertility.

In fact, in the case of the present study, preliminary findings from some of the collected community inventory and ehtnographic data strongly

suggest that the reciprocal relation between development and fertility in the county during the past two decades does not appear to have been nearly so much a matter of socioeconomic improvements adding to and raising the general level of motivation toward family limitation or approval of birth control as such, as it was one of adding to and expanding the overall level of availability and utilization of professionally provided family planning services--including especially the more modern and effective medical contraceptives (i.e., pill, IUD, sterilization). Hence, the present case study may fit just as well, or perhaps even better, into the so-called "contraceptive availability model" of population growth today. Simply stated, the advocates and supporters of this position hold that in most contemporary societies: the level of practice of family limitation and hence fertility decline in various segments of the population is due as much to the level of availability/accessibility of contraceptive delivery systems as it is to the level of socioeconomic status alone (Teachman, et al., 1983). Whatever the historical explanation, however, the fact remains that the general pattern of contraceptive practice and family limitation found in the study community at the present time is very similar to that found throughout much of the rest of American society today.

REPRODUCTIVE BEHAVIOR: FERTILITY MANAGEMENT AND FAMILY LIMITATION

The magnitude and extent of "modern fertility management" within the community today clearly emerges in findings from the interviews with married women in the child-bearing ages (15-44 yrs.).* This is especially evident, for example, in the general level of birth control knowledge, acceptance and

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*The interviewed respondents in this survey represent a twenty four percent age stratified random sample of all enumerated households in the county at the time of the study with married women/couples meeting the definition and criteria for our study population: wives 45 years of age and younger living with their present husbands.

practice reported by women in terms of their 1) perceptions of the availability/accessibility of professionally provided family planning services; 2) approval of birth control for family limitation purposes; 3) family size preferences; 4) knowledge and use of the more effective modern medical contraceptives; and 5) effectiveness in fertility regulation.

Availability/Accessibility: Perceived, rather than objective, contraceptive availability and accessibility is used here. In other words, information on perceived availability and accessibility is taken from the survey data as reported by individuals. It is possible, therefore, that individual perceptions may be correct or incorrect in a particular case. It may be argued, however, that individual perceptions of availability and accessibility exert the greatest influence on current contraceptive use and fertility. Since obviously, a woman cannot actively engage or use the services of an available clinic or other contraceptive outlet unless she knows of its existence and perceives it to be accessible to her.

Objective data on the community do in fact indicate that modern family planning services and contraceptives are readily available in the local area from a wide variety of sources including physicians, clinics, and hospitals. No distinction is made here between these sources of contraceptives, since concern here is with overall availability and accessibility. Likewise, no distinction is made between types of contraceptive services or methods available (i.e., pill, IUD, condom). Individual responses indicating the women's assessment of the availability and accessibility of known family planning services to them are used here to measure the general level of perceived availability/accessibility.

An index, using the percentage distribution of individual responses on these two items, is constructed and scaled into three general categories: 1) no known/perceived available sources, and known available sources perceived

to be 2) hard to use or 3) easy to use in terms of their accessibility. As can be seen in Table 4, the large majority (85%) of respondents reported that they knew of available sources of family planning services and contraceptives which they considered to be readily or easily accessible to them. This demonstrates a close correspondence between the perceived and the observed patterns of contraceptive availability and accessibility in the study community today..

It is axiomatic that age plays a key role in most, if not all, aspects of fertility. In order to examine the influence of age on observed fertility patterns in this study, a major part of the analysis is focused on comparison of three age cohorts among the interviewed women. A primary consideration in this comparison of age cohorts has been to identify possible differences between them on a number of variables including demographic background, birth control use and knowledge, family size preferences, and fertility experience. Initial results of the survey indicate that 25% (102) of the 407 women interviewed were between the ages 15-24; 46% (186) were between the ages of 25-34; and 29% (119) were between the ages of 35-45.

Demographic Background: Comparison of these age groups does, in fact, reveal several areas of variation in their demographic backgrounds. For example, the age cohorts varied in their level of education. The percentage of high school graduates decreased as their age increased: youngest - 37%: middle - 34%; and oldest - 18%. On the other hand, since many of them had generally completed their formal lifetime education, the older women were more likely as a group to have college experience or professional degrees than were the middle or youngest age cohorts (21%; 17%; 8% respectively).

There also appears to be a positive relationship between age and full-time employment. A full 29% of the oldest age cohort worked full-time, compared

to 18% in the middle age group and only 12% of wives in the youngest group. Most women in all three age groups, however, identified themselves as "homemakers": youngest - 79%; middle - 70%; oldest - 68%.

Family income levels varied considerably among the 359 women who reported their financial status. More women in the oldest (16%) and the youngest (20%) age groups indicated annual family earnings of $5,000 or less than did women in the middle age cohort (7%). However, the older women as a group were more likely to indicate family incomes of at least $25,000 than were women in the middle and younger age cohorts (28%; 26%; 14% respectively). The family income status of the three age cohorts was somewhat more evenly distributed in the other annual income brackets.

Birth Control Approval: A relatively high level of acceptance and approval of birth control appears to be a major factor affecting the contemporary pattern of fertility in the local area today. This is evident, for example, in the fact that the great majority (95%) of women in the study, and in each age cohort, approved of birth control for family limitation unconditionally: youngest - 98%; middle - 95%; oldest - 91%. In considering the marital relation as it involves this general approval of birth control, most respondents (70%) thought that both husband and wife should be responsible for birth control, but this opinion was more often expressed by the older than the middle aged or youngest cohorts (76%; 71%; 63%, respectively). Also, younger women (32%) more often than the middle aged group (26%) or the oldest group (19%) thought that the wife should be primarily responsible for family planning decisions.

Family Size Preference/Goals: The general trend in contemporary American society toward relatively "small" family size preferences also appears quite widespread among these married couples in terms of their "ideal"

and "desired" number of children. It should be noted, however, that this present emphasis on 'having smaller families' does not seem to diminish in any appreciable degree the fairly high level of motivation or desire among these married women to have children. Consequently, among all 407 women interviewed, no one indicated that they thought the "ideal" family size would be having "no children." But at the same time, two children seems to be the most common or popular "ideal" number of chidren for women in every age group. On the other hand, there is a definite relationship of this expressed "ideal" to age. For example, a full 78% of the youngest women reported"2" as the ideal number, compared to 67% of those in the middle group and only 50% of the older women.

There also was some discrepancy between the women's general perception of an "ideal" number of children to have and their own personal family size preferences and goals in terms of the number of children they actually "desired" or wanted. For instance, while 50% of the older women indicated "2" as the "ideal" number, only 27% of those women actually wanted 2 children. The youngest women in comparison did indicate a definite "desire" for smaller families. No one in this younger age group wanted a family larger than 5, except for one woman who wanted 7 children. In contrast, the highest number of children wanted among the oldest age cohort was 15 and the highest number given among the middle cohort was 6.

While the age differentials in family size preferences and goals reviewed here are noteworthy, it is important not to loose sight of the fact that the majority (68%) of the 407 women considered the "ideal" number of children for the average American family to be 1 or 2, and the majority (57%) also indicated they "desired" or wanted 2 or less children. Hence, the average "ideal" family size was '2.5' children while the average "desired" family size was '2.7'

children for the 407 women.

Contraceptive Knowledge/Practice: The fertility behavior reported by the respondents in terms of their past and present contraceptive practice fits fairly closely with their relatively high level of approval and motivation toward birth control, as well as their general preference toward "smaller" families. This comes out, for example, in the fact that a large majority (96%) of the 407 women indicated they had practiced birth control at some time. This general pattern of a high level of past contraceptive practice was fairly evenly distributed among the age cohorts; from 99% among the youngest group, to 97% among the middle group, to 93% among the oldest group.

On the other hand, while the level of past contraceptive practice is fairly similar among the age cohorts, there are definite differences between the younger and the older women in terms of both the timing and the method of their intitial contraceptive practice. Hence, in examining the age when the 407 women reported they were first knowledgable about birth control, the survey results show a definite and positive relationship to the respondent's age. For example, more than half (54%) of the younger women felt knowledgable by at least 16 years of age, compared to 19% of those in the middle cohort and only 7% of those in the oldest age cohort. The oldest group (39%) also reported more frequently than the middle group (17%) or the youngest group (1%) that they felt knowledgable about birth control at 22 years of age or older. In addition to feeling more knowledgable about birth control at younger ages, a large number of the youngest cohort (40%), when compared to the middle (12%) and oldest (10%) cohorts, reported they actually had used birth control by at least 16 years of age.

Among the 390 respondents who have used birth control, the method of past contraceptive practice involves a somewhat similar pattern of differences

between the women in the younger and older age cohorts. For instance, while the pill (52%) and condom (29%) were the most frequently cited methods of birth control first used by these women; 39% of the older women reported first using the condom, compared to 27% of the middle age cohort and 21% of the youngest cohort. In contrast, a full 69% of the youngest cohort reported first using the pill, compared to 54% of those in the middle group and only 34% of those in the oldest group. It should be noted that the age differentials among these women in the timing and method of past contraceptive practice holds not only for the entire group who have used birth control, but also for all women who have ever had a pregnancy and ever used birth control. Hence, of the 369 women who have had a pregnancy and used a method of birth control at some time in their life, most (56%) did not practice birth control before their first pregnancy, but this varies among the age cohorts: youngest - 48%; middle - 53%; oldest - 69%. Also, while the majority (75%) of women who did not practice family planning before their first pregnancy began doing so after that pregnancy, the difference between the younger and older women is even more pronounced: youngest group - 95%; middle group - 79%; oldest group - 52%.

Current contraceptive practice is measured here as the proportion of non-pregnant women in the sample who were using any birth control method at the time of the survey. Of the 391 respondents who reported they were not pregnant when interviewed, the large majority (86%) indicated they were using some method of birth control. This varied from 86% in both the youngest and the middle age cohorts to 74% in the oldest age group. Among the 323 women practicing family planning, sterilization is the single most popular method, especially among the oldest (55%) and middle (38%) age cohorts. Although the youngest (20%) age group did have a fairly significant number who use steril-

zation, the pill is used by a larger proportion of this group (43%) than by the middle (28%) and the oldest (6%) groups.

Fertility Regulation Effectiveness/Success: Results of the preliminary analysis of the pregnancy histories reported by the respondents show a definite relationship between age and number of pregnancies. For example, only 15 of the 407 women indicated they were pregnant at the time of the survey, and the large majority of these women were in the youngest (9) and middle (5) age groups as compared to the oldest (1) age cohort. On the other hand, the number of all or total pregnancies increased among the older women. Hence, while 27% of the oldest group reported having only one or two pregnancies, 61% of the middle group and 73% of the youngest group reported one or two pregnancies. Another indication of this increase in total pregnancies with increased age is the average number of pregnancies per women among the younger and older wives. This measure shows an average of 2.4 pregnancies per women for the 407 respondents as a group compared to an average of 1.5 for the youngest group, 2.3 for the middle group and 3.5 for the oldest group.

Our primary concern here, however, is age differentials in reported levels of effectiveness in fertility regulation among respondents. One widely used measure of the effectiveness of contraceptive practice is the proportion of reported unplanned pregnancies among total pregnancies. Using this measure, we find that around one third (33%) of the total 997 pregnancies among the 407 respondents were reported as being unplanned. When we compare the three age cohorts on this measure of fertility regulation effectiveness, the differences between the younger and older women in the rate of unplanned pregnancies appears quite substantial: youngest - 19%; middle - 27%; oldest - 43%. A similar pattern emerges when we consider the actual fertility of the women in terms of the number or proportion of all live births reported as

unplanned. On this measure we find that close to one third (31%) of the total 884 live births for the 407 women were reported as being unplanned. This compares to the following rates of unplanned births for the three age cohorts: youngest - 18%; middle - 26%; oldest - 41%.

Overall, then, it appears from preliminary analysis of the selected survey data reviewed above, that there are definite differences in both fertility and fertility control behavior between the younger and older married women in the study community. The major differentials between the women in these three age groups do not appear, however, to be so much in the general level of birth control approval and use as such, or motivation toward family limitation. Rather, the observed differences seem to be more a matter of the initial timing and method of contraceptive practice, and the effectiveness of fertility regulation. In other words, the preliminary findings from the survey of married women suggest that the younger women in comparison to the older women have tended not only to be knowledgeable about birth control at an earlier age and to start their initial contraceptive practice earlier using the more effective medical contraceptives, but they also seem to have been more effective in their fertility regulation and hence more successful so far in achieving family size goals.

SUMMARY AND CONCLUSION

In summary, preliminary results from our recent field work in a rural and historically "high" fertility community of Central Appalachia indicate a contemporary fertility pattern which appears quite similar to that found in many other rural and urban communities throughout American society today. Evidence is also coming out of these initial findings which strongly suggests that any attempt at "theoretical" interpretation or "historical" explanation

of this present demographic situation in the local area must give more careful attention to the contemporary forces shaping population growth in our own and other modern societies. There is need in our fertility research today, therefore, to take into account the fact that community supported contraceptive delivery systems are often designed to promote the spread of fertility control services without regard to the socioeconomic status of the individuals and families involved. This is certainly the case of many modern family planning programs aimed at less "developed" groups or communities (Ravenholt, R. and J. Chao 1974; Freedman, R., and B. Berelson 1976).

This does not in any way imply, however, that socioeconomic development has not played a role, or does not continue to exert an important influence, on the contemporary pattern of population growth in modern society. In fact, while the proponents of the so-called "contraceptive availability model" stress the efficacy of contraceptive delivery systems in fertility control, they do not reject the "developmental model" of population growth. Instead, they argue that modern family planning services may, and in many cases do, remove the technical, socioeconomic, and other barriers confronting couples wishing to limit childbearing (Teachman, et al., 1983). The present study would seem to lend some additional support for this position on population growth in much, if not most, of American society today--including Central Appalachia.

TABLE 1. COUNTY CENSUS POPULATION AND CHANGE 1900 - 1980

Population		Inter-censal Change Decade	Net Change	% Change
1980	14,882	1970-1980	3,259	28.0%
1970	11,623	1960-1970	682	6.3%
1960	10,941	1950-1960	-4,596	-29.6%
1950	15,537	1940-1950	600	4.0%
1940	14,937	1930-1940	4,172	39.2%
1930	10,765	1920-1930	668	6.6%
1920	10,097	1910-1920	1,121	12.5%
1910	8,976	1900-1910	2,223	32.9%
1900	6,753	1890-1900	2,789	70.4%
1890	3,964			

COMPONENTS OF INTER-CENSAL CHANGE

Years	Births	Deaths	Natural Increase	% Total Pop. Change Due to Natural Inc.	Net Migration
1970-1980	2,657	987	1,679	51.5	+1,580
1960-1970	3,500	770	2,730	400.2	-2,048
1950-1960	5,565	708	4,857	105.6%	-9,453
1940-1950			4,731	778.5%	-4,131

TABLE 3. COUNTY: WOMEN OF CHILD-BEARING AGE (15-44 Years) 1960-1980

WOMEN OF CHILDBEARING AGE (15-44 Yrs.)

Year	Population	Inter-censal Change Decade	Net Change	% Change
1980	3321	1970-1980	920	38.3%
1970	2401	1960-1970	395	19.7%
1960	2006			

COMPONENTS OF INTER-CENSAL CHANGE

Female Population	1980	1970	1960	% Change 1970-1980	% Change 1960-1970
15-19	705	649	499	8.6%	30.1%
20-24	802	423	348	89.6%	21.6%
25-29	636	323	320	96.9%	0.9%
30-34	442	371	289	1.9%	28.4%
35-39	351	322	301	9.0%	7.0%
40-44	385	313	249	23.0%	25.7%
Total	3321	2401	2006	38.3%	19.7%

TABLE 4. PERCENT DISTRIBUTION OF LEVEL OF PERCEIVED AVAILABILITY/ ACCESSIBILITY AMONG SURVEY RESPONDENTS

Level of perceived availability/accessibility	Married women (15-45 yrs.)	
N (total number)	407	(100%)
None known/available	4.2%	(N 17)
Known/hard to use	8.6%	(N 35)
Known/easy to use	85.0%	(N 346)
No Response	0.2%	(N 9)
	100.0%	(N 407)

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